

Oakland County Retiree Health Enrollment Form

Last Name	First Name	MI	Date of Birth	
			Male <input type="checkbox"/> Married <input type="checkbox"/>	/ /
			Female <input type="checkbox"/> Single <input type="checkbox"/>	
Home Address		City	State	Zip code
Telephone	SSN #	Employee ID #	Date of Retirement	
	- -		/ /	

Select One Medical Option (non-Medicare)

- | | |
|-------------------------------------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> BCBSM Traditional | <input type="checkbox"/> BCBS Comprehensive |
| <input type="checkbox"/> Blue Preferred Plan (PPO) | <input type="checkbox"/> Major Medical (CMM) |
| <input type="checkbox"/> Blue Choice (POS) | <input type="checkbox"/> No Medical Coverage |
| <input type="checkbox"/> Health Alliance Plan (includes HAP prescription drug plan) | |

Are you or any enrolled dependents Medicare eligible? Yes ___ No ___

Relationship	Medicare #	Part A	Part B
Yourself			
Spouse			
Dependent			

Aetna Complimentary Coverage

Select One Dental Option

- Standard Dental Coverage
 No Dental coverage

Select One Vision Option

- Standard Vision Coverage
 No Vision Coverage

Prescription Drug Plan

- Oakland County Prescription drug plan
 Waive Oakland County prescription drug plan

Are you or any enrolled dependents enrolled in Medicare Part D? Yes / No ___

List primary Physician and Physician code for <u>Blue Choice POS plan only</u> →	Primary Physician	Physician Code
		Name

IMPORTANT: List all family members you are covering. Include last name if different from Retirees. See reverse side for childrens eligibility guidelines.

Name	SSN	Birth date	Sex	Relationship	Physician code for POS
1					
2					
3					
4					
5					

I apply on behalf of myself and eligible family members as listed for enrollment in the health plan selected above as currently offered through Oakland County. I hereby revoke all previous enrollment applications executed by me for hospital and Medical coverage made available by Oakland County.

No matter which health plan you choose you elect a plan not a specific provider. If you or an eligible family member are enrolled in a Medicare Part D prescription drug plan you cannot be enrolled in the Oakland County prescription drug plan.

If I selected the NO COVERAGE/WAIVE option I realize my next opportunity to enroll in coverage may be as long as 1 (one) year from this date. *I agree to the terms and conditions on the reverse side of this form and certify that the above information is true and correct.*

 Subscribers Signature Date

THIS SECTION FOR OFFICE USE ONLY

Effective Date _____ Group/Suffix _____ Service Code _____

Notes/Comments:

Retiree Health Plan Enrollment Form Terms & Conditions

Your signature on the front side of this form indicates your understanding that Oakland County will enroll you and your eligible dependents for hospital, surgical, medical, dental, vision and prescription drug coverage made available by Oakland County for which you are eligible and which you have not waived or canceled. With the health carrier you have elected and constitutes your authorization to Oakland County or any of its agents to release to all carriers or organizations, as applicable the information contained on this form.

Your signature on the front side of this form constitutes your authorization to any health care coverage carrier, organization, employer, Medicare approved organization or provider of services to release any information requested with respect to a claim to the health carrier in which you are enrolled, or to the state or federal government in situations involving processing or auditing of claims or investigation for fraud.

Your signature on the front side of this form constitutes your authorization to Oakland County, until this authorization is revoked by you in writing, to deduct in advance each month from any earned or accrued wages due you or from pension or retirement benefits due you, such amount as may be necessary to make any contributions required of you. These include, by way of example, but not limited to, amounts for dependent coverage, health maintenance organization coverage and County health care contribution amounts.

You may enroll your unmarried children legally residing with you who are either your own, OR legally adopted, or by marriage for which you provide principal support as long as such children are dependents within the meaning of the Internal Revenue Service Code and meet additional restrictions specific to the plan selected. Such children can be covered up to December 31st of the year in which they become 25 years old. Contact the Human Resource Office for further information.

If you have elected coverage through a health maintenance organization, you and your covered dependents agree that all your medical services must be performed, prescribed, directed or authorized by your designated primary care physician(s) except in the case of accidental injury or life-threatening medical emergency, when it is not possible or practical to contact your designated primary care physician.

Other terms and conditions apply according to the specific plan in which you are enrolled.